U.S. Department of Labor

Office of Administrative Law Judges
800 K Street, NW, Suite 400-N
Washington, DC 20001-8002

(202) 693-7300
(202) 693-7365 (FAX)

Issue Date: 24 August 2007

In the Matter of:
W.K. (deceased) and
B.K.[1]**, WIDOW OF**
W.K.
Claimant

v.

Case No.: 2007-BLA-05124
Case No.: 2005-BLA-00022

KOCH CARBON, INC.
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

APPEARANCES:
Brenda Yates, Lay Representative
For the Claimant

Michael Blair, Esq.
For the Employer

BEFORE: DANIEL F. SOLOMON
Administrative Law Judge

DECISION AND ORDER

DENIAL OF REQUEST FOR MODIFIFICATION IN LIVING MINER'S CLAIM
DENIAL OF SURVIVOR'S CLAIM

This matter involves a consolidated claim. The miner and his widow have filed separate claims (living miner's claim and survivor's claim) for disability benefits under the Black Lung Benefits Act, Title 30, United States Code, Sections 901 to 945 ("the Act"), as implemented by 20 C.F.R. Parts 718 and 725. Benefits are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis, or to survivors of persons who die due to

[1] Effective August 1, 2006, the Department of Labor instituted a policy that decisions and orders in cases under the Black Lung Benefits Act which will be available on this Office's website shall not contain the claimant's name. Instead, the claimant's initials will be used.

pneumoconiosis. Pneumoconiosis is a dust disease of the lung arising from coal mine employment and is commonly known as "black lung" disease.

PROCEDURAL HISTORY

This case comes before me with a long and extensive procedural history. The miner filed a claim for benefits on February 5, 1993. (DX1-1) The miner last worked in the coal mines in Oakwood, VA (DX1-2) The District Director made an initial determination of eligibility on September 2, 1993 (DX1-47) The Employer contested the preliminary decision awarding benefits and requested a hearing before an Administrative Law Judge ("ALJ"). The claim was referred to the Office of Administrative Law Judges on February 10, 1994 and assigned to Judge Stuart Levin.

A hearing was held in Abingdon, VA on June 27, 1994 before Judge Levin, who subsequently issued a Decision and Order on September 22, 1994 denying benefits (DX1-56) Judge Levin found the miner suffering from a totally disabling pulmonary impairment, but not due to pneumoconiosis. Judge Levin also concluded that miner had failed to establish the presence of pneumoconiosis. Judge (DX 56) On October 21, 1994, the miner appealed Judge Levin's Decision to the Benefits Review Board ("BRB"). The BRB affirmed the denial of benefits on June 28, 1995. (DX 68)

The Employer submitted a medical report prepared by Dr. H. Patel and, on August 22, 1995, requested modification of the Decision. (DX1-65) The District Director issued a Proposed Decision and Order denying modification on June 25, 1996 (DX1-68,73) On December 10, 1996, the Claimant made a request for a formal hearing. (DX 82) The case was transferred to this office and assigned to Judge Jeffrey Tureck. A hearing was held before Judge Tureck on August 14, 1997, in Abingdon, VA. (DX 91) and on December 8, 1997, a Decision and Order issued denying benefits. Judge Tureck concluded that the miner's condition had not changed since Judge Levin's prior denial in September 1994. (DX 92) The Claimant appealed Judge Tureck's Decision to the BRB. (DX 93) The BRB affirmed Judge Tureck's finding that Claimant had failed to demonstrate a change in condition on the issue of total disability due to pneumoconiosis, but vacated Judge Tureck's finding that the Claimant failed to show a change in conditions in establishing pneumoconiosis because Judge Tureck did not consider whether the newly submitted evidence established a change in conditions for the presence of pneumoconiosis. On remand, Judge Tureck denied benefits, finding that the new evidence established the presence of pneumoconiosis, but the miner had failed to establish total disability due to pneumoconiosis. The Claimant once again appealed the Decision on Remand. The BRB affirmed the Decision on June 11, 2000. (DX 110)

Another request for modification was made on June 4, 2001, submitting in support of the request, medical reports from Drs. Alexander and D.N. Patel. (DX 114) The District Director issued a Proposed Decision and Order denying modification on June 26, 2001. (DX 116) A request for a formal hearing was submitted. The case was transferred to this office and assigned to Judge Pamela Wood. On May 10, 2002, Judge Wood issued a Decision and Order denying the Claimant's modification request. Judge Wood held that the newly submitted evidence, either alone or in connection with other evidence of record, did not establish the presence of pneumoconiosis. Following the Decision, an unopposed Motion for Continuance was requested by the Claimant and granted.

The case was continued and reassigned to me on October 16, 2002. I held a hearing in this case in Bristol, VA on February 27, 2003. (DX 150) Subsequently, Claimant made a request

for remand to the District Director for further development of the evidence. I granted the request and remanded the case back to the District Director. (DX 151)

On June 2, 2003, the District Director issued a Proposed Decision and Order denying request for modification. (DX 161) On May 18, 2004, the Claimant submitted several new medical records and requested a modification of the District Director's Decision. (DX 164) The District Director, in a Proposed Decision and Order issued August 25, 2004, found the presence complicated pneumoconiosis and concluded that the Claimant had established that he was totally disabled. The Director awarded benefits to the Claimant. (DX 165) On September 15, 2004, the Employer requested a formal hearing before an ALJ. (DX 166)

The case was referred to this office and assigned to Judge Stephen L. Purcell. (DX 181) A hearing was initially scheduled for May 10, 2005.

The miner died on March 15, 2005.

On March 30, 2005, a Motion for Continuance was requested and granted. The hearing was rescheduled for September 20, 2005, in Abingdon, VA, before Judge Edward Terhune Miller. (DX 188) In light of the miner's passing, an Order of Remand was issued by Judge Miller to permit the miner's spouse to file a survivor's claim and have the two claims consolidated. (DX 195)

The miner's widow (Claimant) filed a survivor's claim for benefits on October 27, 2005. The District Director issued a schedule for submission of additional evidence on March 15, 2006, setting forth a preliminary finding that the Claimant was entitled to benefits. A Proposed Decision and Order granting modification on the living miner's claim was issued on June 26, 2006. (DX 196). A Proposed Decision and Order followed on June 30, 2006, awarding benefits to the Claimant in the survivor's claim. On August 7, 2006, the Employer requested a formal hearing. The case now comes before me as consolidated living miner's claim and survivor's claim for benefits under the Black Lung benefits Act.

The case was referred to this office and assigned to me. I held a hearing in Abingdon, VA on April 25, 2007. During the hearing, I admitted into the record of the living miner's claim exhibits GX1 – GX199, and EX1-EX29 for identification purposes. I admitted into the record of the survivor's claim exhibits DX1 – DX44.

Widow's Testimony – April 25, 2007

Direct Examination

Claimant testified that she lived with her husband from the time they were married in 1972 until his death in 2005, and that she has not remarried since the death of her husband (miner). Her husband worked as a coal miner during the entire time they were married. She testified that he was a pinner operator; that he came home covered in coal dust. She stated that his health deteriorated over the years to the point where he could not breathe because of his health; that he smoked approximately ½ pack of cigarettes a day and quit smoking about 10 to 12 years before he died. During the last six months of his life he could not go fishing or hunting; activities he enjoyed very much. He had a hard time walking through the house because of his breathing problem.

Cross Examination

On cross-examination, the Claimant testified that the miner smoked every now and then from 1972 onwards, but not very often. The miner stopped smoking about 15 years before he died. He smoked an average of 1 pack per day. The Claimant stated that her husband had been treated for tuberculosis, and was first diagnosed about 2 years before he died, by Drs. D. Patel and H. Patel. About 6 months before he dies they determined he did not have tuberculosis. He was treated

from the time he was first diagnosed. Her husband stopped working in the coal mines because it got to the point where he couldn't breathe and they put him on oxygen. She also testified that to the best of her knowledge, the miner did not have any heart problems.

Re-Direct

When the Doctors indicated that he did not have tuberculosis, they said that it was because of his lungs, he had to stop working in the mines.

APPLICABLE STANDARDS

Because the Claimant filed this application for benefits after March 31, 1980, the regulations set forth at part 718 apply. ***Saginaw Mining Co. v. Ferda***, 879 F.2d 198, 204, 12 B.L.R. 2-376 (6th Cir. 1989). This claim is governed by the law of the United States Court of Appeals for the Fourth Circuit, because the Claimant was last employed in the coal industry in the Commonwealth of Virginia within the territorial jurisdiction of that court. ***Shupe v. Director, OWCP***, 12 B.L.R. 1-200 (1989) (en banc). (DX 5)

This case represents a consolidated claim for benefits; a request for modification on an initial living miner's claim for benefits as well as an initial survivor's claim for benefits. To receive black lung disability benefits under the Act in a living miner's claim, a miner must prove that (1) he suffers from pneumoconiosis, (2) the pneumoconiosis arose out of coal mine employment, (3) he is totally disabled, and (4) his total disability is caused by pneumoconiosis. ***Gee v. W.G. Moore and Sons***, 9 B.L.R. 1-4 (1986) (en banc); ***Baumgartner v. Director***, OWCP, 9 B.L.R. 1-65 (1986) (en banc). ***See Mullins Coal Co., Inc. of Virginia v. Director***, OWCP, 484 U.S. 135, 141, 11 B.L.R. 2-1 (1987). The failure to prove any requisite element precludes a finding of entitlement. ***Anderson v. Valley Camp of Utah, Inc.***, 12 B.L.R. 1-111 (1989); ***Perry v. Director***, OWCP, 9 B.L.R. 1-1 (1986) 1-1 (1986) (en banc).

In order to receive benefits in a survivor's claim, the claimant must prove: (1) that the miner had pneumoconiosis, (2) the miner's pneumoconiosis arose out of coal mine employment, and (3) the miner's death was due to pneumoconiosis. 20 C.F.R. § 718.205(a). A miner's death was due to pneumoconiosis if: (1) competent medical evidence establishes that the miner's death was due to pneumoconiosis, (2) pneumoconiosis was a substantially contributing cause or factor leading to the miner's death or the death was caused by complications of pneumoconiosis, or (3) the presumption for complicated pneumoconiosis at § 718.304 is applicable. 20 C.F.R § 718.205(c)(1) – (3). However, survivors are not eligible for benefits where the miner's death was caused by a traumatic injury or the principal cause of death was a medical condition not related to pneumoconiosis, unless the evidence establishes that pneumoconiosis was a substantially contributing cause of death. 20 C.F.R. § 718.205(c)(4).

STIPULATIONS AND WITHDRAWAL OF ISSUES[2]

Living Miner's Claim and Survivor's Claim

1. The named employer is the responsible operator.
2. The person upon whose death or disability the claim is based is a miner.[3]
3. The miner worked as a miner after December 31, 1969.[4]

[2] These stipulations were made at the hearing held in Big Stone Gap, VA, on April 25, 2007. The Employer also withdrew previous assertions that the claim was untimely filed; however, timeliness is not an issue that can be waived.

[3] *See* page 10 of Transcript of hearing held in Abingdon, VA on April 25, 2007.

[4] *Id*.

4. The Employer stipulates to twenty three (23) years of coal mine employment.[5]
5. The Employer is the responsible operator and has secured the payment of benefits.[6]
6. There is a joint stipulation as to no dependents for augmentation purposes.[7]

I have reviewed all of the evidence in the record and the stipulation is approved.

ISSUES[8]

Living Miner's Claim

1. Whether the miner has established the presence of pneumoconiosis.
2. If so, whether the pneumoconiosis arose out of coal mine employment.
3. Whether the miner is totally disabled.
4. If so, whether the miner's disability is due to pneumoconiosis.

Survivor's Claim

1. Whether the miner has Pneumoconiosis.
2. If so, whether the pneumoconiosis arose out of coal mine employment.
3. Whether the miner's death was due to pneumoconiosis.

BURDEN OF PROOF

"Burden of proof," as used in this setting and under the Administrative Procedure Act[9] is that "[e]xcept as otherwise provided by statute, the proponent of a rule or order has the burden of proof." "Burden of proof" means burden of persuasion, not merely burden of production. 5 U.S.C. § 556(d).[10] The drafters of the APA used the term "burden of proof" to mean the burden of persuasion. ***Director, OWCP, Department of labor v. Greenwich Collieries [Ondecko]***, 512 U.S. 267, 18 B.L.R. 2A-1 (1994).[11]

A Claimant has the general burden of establishing entitlement and the initial burden of going forward with the evidence. The obligation is to persuade the trier of fact of the truth of a proposition, not simply the burden of production; the obligation to come forward with evidence to support a claim. Therefore, the Claimant cannot rely on the Director to gather evidence. The

---

[5] *Id*.

[6] *See* page 11 of transcript of hearing in Big Stone Gap, VA, held on April 25, 2007.

[7] *Id* at page 11.

[8] The Employer's objection to the evidentiary limitations enacted in the amended regulations is noted and preserved for appellate purposes.

[9] 33 U.S.C. § 919(d) ("[N]otwithstanding any other provisions of this chapter, a hearing held under this chapter shall be conducted in accordance with [the APA]; 5 U.S.C. § 554(c)(2). Longshore and Harbors Workers' Compensation Act ("LHWCA") 33 U.S.C. § 901-950, is incorporated by reference into Part C of the Black Lung Act pursuant to 30 U.S.C. § 932(a).

[10] The Tenth and Eleventh Circuits held that the burden of persuasion is greater than the burden of production, ***Alabama By-Products Corp. v. Killingsworth***, 733 F.2d 1511, 6 B.L.R. 2-59 (11th Cir. 1984); ***Kaiser Steel Corp. v. Director***, OWCP [Sainz], 748 F.2d 1426, 7 B.L.R. 2-84 (10th Cir. 1984). These cases arose in the context where an interim presumption is triggered, and the burden of proof shifted from a Claimant to an employer/carrier.

[11] Also known as the risk of non-persuasion, *see* 9 J. Wigmore, Evidence § 2486 (J. Chadbourn rev. 1981).

Claimant bears the risk of non-persuasion if the evidence is found insufficient to establish a crucial element. ***Oggero v. Director, OWCP***, 7 B.L.R. 1-860 (1985).

MEDICAL EVIDENCE – LIVING MINER'S CLAIM[12]

The following is a summary of evidence admitted into the record at the hearing held in Big Stone Gap, Virginia on April 15, 2007. The designation of evidence already in the record is not necessary for claims adjudicated under the pre-amended regulations. The amended regulations at part 725 and 718 are not applicable to the living miner's claim.

Chest x-rays

Date of X-Ray	Date of Reading	EXH.	Physician	Interpretation
2/19/1993	9/18/2002	EX6	**Dr. Scatarige B/BCR**	FQ 2; no pleural or parynchemal abnormalities; not completely negative; pulmonary vascular prominence; cannot exclude subtle interstitial edema or fibrosis in lower lobes. No evidence of CWP/silicosis.
7/30/2002	9/30/2002	EX1	**Dr. Dahhan B/BCR**	See footnotes[13]
7/30/2002	8/10/2002	EX3	**Dr. Dahhan B/BCR**	FQ 2; no pleural or parynchemal abnormalities; not completely negative; probable TB; cannot rule out cancer.
7/30/2002	9/18/2002	EX4	**Dr. Scatarige B/BCR**	FQ 2; no pleural or parynchemal abnormalities; not completely negative; many bilateral masses; ddx is active TB; no definite background to suggest CWP.
7/30/2002	9/20/2002	EX5	**Dr. Wheeler B/BCR**	FQ 2; no pleural or parynchemal abnormalities; not completely negative; probable pleural fibrosis; cavitary masses in right and left lung
11/19/2002	08/19/2004	EX10	**Dr. Scott B/BCR**	FQ 2; no pleural or parynchemal abnormalities; not completely negative; 10 cm mass right upper lung and 6 cm mass in left upper lung, and 10 x 4 cm mass in left mid-lung; left apex thickened pleura; changes could be TB, atypical TB; sarcoidosis; cannot rule out cancer.
11/19/2002	08/19/2004	EX11	**Dr. Scatarige B/BCR**	FQ 2; no pleural or parynchemal abnormalities; not completely negative; several masses ranging from 6 to 9 cm in mid, upper and lower lungs; no small opacities to suggest CWP/silicosis;

[12] This summary of medical evidence lists the additional new evidence admitted into the record on behalf of the Employer. It does not represent the complete evidence to be considered. There are no evidentiary limitations under the pre-amended regulations. Thus, all evidence of record admitted subsequent to the prior denial will be considered new evidence.

[13] Employer designated EX1 as a reading of the July 30, 2002, x-ray by Dr. Dahhan. The exhibit referred to is a medical report and examination by Dr. Dahhan summarizing x-ray readings by other physicians. Dr. Dahhan does not provide an x-ray interpretation of the July 30, 2002 x-ray.

				volume loss both upper lungs.
2/11/2003	11/3/2003	EX12	**Dr. Scatarige B/BCR**	FQ 2; no pleural/parynchemal abnormalities; not completely neg.; bilateral opacities left upper lobe, right and left mid lung, measuring 5x7 cm, 3.5 cm, and 6x8 cm, respectively. Pneumonia, TB, non-TB myobacterial, cancer, infection, sarcoidosis; obtain tissue diagnosis; no small round opacities to suggest pneumoconiosis.
2/11/2003	11/3/2004	EX13	**Dr. Scott B/BCR**	FQ 1; no pleural/parynchemal abnormalities; not completely neg.; bilateral dense infiltrates and/or masses; probably TB, sarcoidosis; No background of rounded opacities to suggest silicosis/CWP.
9/1/2003	10/21/2004	EX14	**Dr. Scatarige B/BCR**	FQ 2; no pleural or parynchemal abnormalities; not completely negative; several masses notes in right, left, and mid-lung, measuring 5cm, 5x7 cm. Absence of small opacities and pleural based processes are against CWP/silicosis. Scattered calcified granulomas in right lung.
9/1/2003	10/21/2004	EX15	**Dr. Scott B/BCR**	FQ 2; no pleural or parynchemal abnormalities; not completely negative; 12x7 cm mass mid lung, 8cm mass mid left lung. TB is most likely diagnosis, tissue diagnosis should be done.
1/7/2004	10/21/2004	EX16	**Dr. Scott B/BCR**	FQ 2; no pleural or parynchemal abnormalities; not completely negative; 12x7 cm mass mid lung, 7cm mass mid left lung. Probable TB
1/7/2004	10/21/2004	EX17	**Dr. Scatarige B/BCR**	FQ 2; no pleural or parynchemal abnormalities; not completely negative; bilateral masses/infiltrate; pleural extension favors TB/mycobacterium, sarcoidosis, pneumoconiosis unlikely in absence of small opacities and in light of pleural extension.
8/10/2004	8/5/2005	EX18	**Dr. Scott B/BCR**	FQ 2; 14 cm mass right mid upper lung and 16 cm mass left mid upper lung; involvement of pleura; no background of small opacities; probable TB; unknown activity; fibrosis versus effusion.
8/10/2004	8/8/2005	EX19	**Dr. Scatarige B/BCR**	FQ 2; no pleural or parynchemal abnormalities; not completely negative; 8x12 cm mass in right mid lung;
8/10/2004	8/10/2004	CX8	**Dr. Hareshbhai Patel**	Shows what appears to be complicated pneumoconiosis with emphysema.
3/05/2004	3/12/2004	CX27	**Dr. Hareshbhai Patel**	Difficult to rule out pulmonary infiltrates.
9/23/2004	9/24/2004	CX7	**Dr. D. Patel BCR**	Large densities most likely related to complicated pneumoconiosis.
9/23/2004	8/8/2005	EX20	**Dr. Scott B/BCR**	FQ 2; no pleural or parynchemal

				abnormalities; not completely negative; 15 cm mass right mid-upper lung and 16cm mass left mid upper lung, adjacent pleural involved. No small nodular background; changes probably TB, unknown activity; pleural fibrosis or effusion.
9/23/2004	8/8/2005	EX21	**Dr. Scatarige B/BCR**	FQ 2; no pleural or paryncheml abnormalities; not completely negative; bilateral masses unchanged since 8/2004; favor conglomerate TB; probably small effusion vs. pleural fibrosis; emphysema; no definite background small opacities to suggest CWP/silicosis.

Review of Biopsy Slides/Cytopathology Reports

Date of Exam	**Physician/Facility**	**EXH.**
10/26/2004	**Dr. Naeye**	EX2

Dr. Naeye reviewed several biopsy slides. All but 2 of the slides have smeared cells, presumably from coughed up mucous. In the absence of pulmonary parenchymal tissue, there is no possibility of making or excluding the diagnosis of coal workers' pneumoconiosis. Two slides each have serial sections of 5 tiny pieces of lung tissue taken from the wall of a bronchiole. There is a small amount of black pigment present in this tissue, but no fibrous tissue with admixed collagen and very tiny birefringement crystals of toxic silica. These later findings are the minimum findings required for the diagnosis of CWP. None of the voluminous findings in this case demonstrate any of the characteristic findings of coal workers' pneumoconiosis.

09/01/2004 **Dr. Haresh J. Patel** Not specified
Dr. Patel examined, under microscope, 1cc of clear sputum. Examination revealed no malignant cells present and very few carbon containing pigment histiocytes were present.

02/13/2003 **Dr. Joseph Segen** Not specified
Dr. Segen examined tissue from a right upper lobe biopsy. Examination reveals fragments with acute and chronic inflammation. Negative for malignancy.

12/14/2004 **Highlands Pathology** CX2
Negative. No malignant cells found. Acute inflammation of bronchial cells and squamous cells.

Other Evidence (CT-Scan)

Date of Exam	**Physician/Facility**	**EXH.**
4/15/2002	**Dr. Scott**	EX8

6 cm mass and adjacent thickened pleura in the left upper lobe. Mass probably has necrotic center. Few smaller masses lateral and inferior to left hilum. 10 cm cavitary mass right upper lobe adjacent to thickened pleura and extending down to hilum. 6 cm cavitary mass right lower lung. The above changes are probably due to tuberculosis. Bullous emphysema upper lungs.

There is no background of small rounded radiodensities to suggest silicosis/CWP. The masses cannot be large opacities of silicosis/CWP.

Hospital Notes – Treatments/Procedures

Date of Exam	Physician/Facility	EXH.
4/17/2002	**Dr. J. G. Patel**	EX27

Dr. J.G. Patel performed a bronchoscopy with endobronchial biopsy. Mild, diffuse emphysematous changes and small amount of secretions noted in the left bronchial tree. No apparent endobronchial tumors or lesions were noted in the left bronchial tree. Right middle, upper and lower lobes showed similar physical changes and characteristics.

5/10/2002	**Dr. H. Patel** **Buchanan General Hospital** **(Discharge Summary)**	EX28

Discharge diagnosis is acute pulmonary tuberculosis, organism isolated mycobacterium tuberculosis, complex. Secondary diagnosis of COPD, complicated coal workers' pneumoconiosis, pleurisy, degenerative arthritis, chronic dyspepsia, and abnormal pulmonary function test with obstructive and restrictive components.

9/10/2002	**Russell County Health Department** **Div. of TB Control**	EX29

Miner reports improvement in apetite, denies night sweats, fevers, or chills. Despite patient reported improvement, the patient has failed to show a bacteriological response to what should have been adequate anti-tuberculosis chemotherapy. He appears to now have developed drug resistance. The etiology of acquired drug resistance and treatment failure in this patient is unclear. Non-adherence and variable absorption could be possible causes.

MEDICAL EVIDENCE – SURVIVOR'S CLAIM

The following is a summary of the evidence of record:

Chest x-rays

Date of X-Ray	Date of Reading	EXH.	Physician	Interpretation
9/23/2004	8/8/2005	EE1	**Dr. Scatarige B/BCR**	FQ 2; no opacity size indicated; no pleural or paryncymal abnormalities; bilateral masses, emphysema, indicated in comments. Evidence favors conglomerate TB or non-TB mycobacterium. No definite small opacity for silicosis/CWP.
9/23/2004	10/7/2004	DX13	**Dr. Hareshbhai Patel**[14]	Large densities most likely related to complicated pneumoconiosis.
4/9/2002	4/19/2002	DX13	**Dr. Ahmed**	FQ 2; no pleural abnormalities but there are parynchemal abnormalities; profusion 1/2; r/r; Size C opacities found in all lung

[14] Dr. H. Patel is not certified as a B-Reader and is not board-certified in radiology.

				zones; comparison with old films to exclude acute inflammatory process.

Medical Reports

Date of Exam	Physician/Facility	EXH.
5/9/2006	**Dr. Fino**	DX14

In 1994, Dr. Fino had examined the miner and reviewed medical evidence from which he concluded that there was insufficient evidence to diagnose pneumoconiosis. It was Dr. Fino's opinion that the miner did have a disabling respiratory disease but that impairment was unrelated to the inhalation of coal mine dust.

Dr. Fino now reviews more recent medical evidence consisting of a handwritten office note from 1988, chest x-ray from June 1989, hospital admissions from February 18, 1991 to February 23, 1991, chest x-ray taken in 1993, a medical report prepared on September 1993 by Dr. Dahhan, medical reports from Dr. Patel dated July 1995, January 1994, November 1996, September 1996, and October 2000, chest x-rays from May 1999, and April 2002, CT scans of April 2002 read by Drs. Wheeler, Scott, and Scatarige, Bronchoscopy report of April 2002, Hospital admission of April 22, 2002 to May 10, 2002, a medical report of an examination on July 30, 2002 by Dr. Dahhan, medical report by Dr. Michos on August 1996, a medical report by Dr. Sargent on October 1996CT Scan of 1996. In addition, the evidence reviewed noted regarding the miner at the Health Department, radiographic review by Dr. Wheeler on November 2002, chest x-ray dated November 2002, chest x-ray November 29, 2002, hospital admission from February 11, through February 18, 2003, hospital admission from August 21 through August 25, 2003, a pulmonary function test in March 2003, hospital admission dated August 21 through August 27, 2005,Readings of a chest x-ray September 2003, hospital admission from October 23 through October 27, 2007. and November 13 through November 18, 2003, a chest x-ray dated December 11, 2003, hospital admission records from December 2003 through August 2004, cytology report dated September 2004, pathology report of October 2004, hospital admission reports from September 23 to October 1, 2004, and from November 9 to November 16, 2004, a report of Dr. Byers dated November 22, 2004, cytopathology report of December 2004.

Based on Dr. Fino's observations, the miner's lung function between 1989 and 1993 was normal with the exception of hypoxemia, which has persisted throughout the subsequent years. Pulmonary function studies that were reviewed between 1993 and 1996 unequivocally showed no evidence of a respiratory impairment or disability; there was some resting hypoxemia present, but it disappeared with exercise. As of 1996, there appeared no evidence suggesting a large opacity. There was no evidence of a restrictive or obstructive lung disease. Dr. Patel's diagnosis of COPD is erroneous because there was never any evidence of obstructive lung disease.

According to Dr. Fino, something happened between 1996 and 1999. All of a sudden, the miner developed large masses within his lungs. There were varying diagnoses from category B complicated pneumoconiosis to simple pneumoconiosis, related to tuberculosis. The CT-Scan from April 2002 showed that these large masses had air fluid levels within them. The central portions were necrotic, which certainly raises suspicions of tuberculosis. The bronchoscopy showed active tuberculosis. Therefore, the large masses cannot be explained by complicated pneumoconiosis. His condition deteriorated between 2000 and 2005; he had drug resistant tuberculosis. There is no justification for a diagnosis of complicated pneumoconiosis. There may be a justification of simple pneumoconiosis based on some of the x-rays. Prior to the

development of the tuberculosis, the miner did not have respiratory impairment or disability. He did have resting hypoxemia. However, it was not severe enough to cause disability and it was shown to reverse with exercise. That rules out pneumoconiosis as a cause of the hypoxemia. Hypoxemia due to coal mine dust inhalation does not improve with exercise. I can state that this miner's disabling respiratory impairment was caused exclusively by tuberculosis. Had it not been for tuberculosis, this miner would not have been disabled. Coal mine dust did not cause, contribute to, or participate in any pulmonary impairment or disability. Coal mine dust inhalation did not cause, contribute to, or hasten the miner's death.

11/29/2004 **Dr. Byers** DX12
Hemoptysis, cavitary lung disease, conglomerate CWP, hypoxemic respiratory failure.

1/25/2005 **Dr. Byers** DX12
Coal workers' pneumoconiosis, massive fibrosis, post TB with INH resistance.

Hospital Treatment Reports

Date of Exam	**Physician/Facility**	**EXH.**
05/23/2004	**Dr. Harish Patel**	DX13

Complicated coal workers' pneumoconiosis, hiatal hernia, history of TB. Degenerative arthritis of cervical spine and left shoulder joint. Acute bronchitis with bronchospasm with pleurisy with chest pain. COPD with acute exacerbation. Esophagitis.

Other Evidence CT-Scan

Date of Exam	**Physician/Facility**	**EXH.**
01/25/2005	**Dr. Scatarige**	EE4

No evidence of small round opacities to suggest CWP/silicosis and no pleural plaques are identified. Bilateral necrotic lung masses. The masses extend to the pleura with a small right pleural effusion. TB or non-TB mycobacterial infection. Calcification in right and left coronary arteries.

Other Evidence – Digital X-Ray

Date of Exam	**Physician/Facility**	**EXH.**
12/31/2004	**Dr. Scott**	EE2

Some areas of dense consolidation or masses. TB is the most likely diagnosis in this case.

Other Evidence – Death Certificate

03/15/2006 **Dr. Hareshbhai Patel** DX13
Death certificate – acute hypoxemic respiratory failure/coal workers' pneumoconiosis.
The miner died on March 15, 2005. Dr. H. Patel, the attending physician, listed the immediate cause of death as acute hypoxemic respiratory failure and secondary cause as coal workers' pneumoconiosis.

FINDINGS OF FACT

TIMELINESS

The Employer withdrew its initial assertion that the present claim for Black Lung benefits was untimely. However, timeliness is a jurisdictional matter that can not be waived. 30 U.S.C. §

932(f), provides that "[a]ny claim for benefits by a miner under this section shall be filed within three years after whichever of the following occurs later": (1) a medical determination of total disability due to pneumoconiosis; or (2) March 1, 1978. The Secretary of Labor's implementing regulations at 20 C.F.R. § 725.308 sets forth in part, as follows:

(a) A claim for benefits filed under this part by, or on behalf of, a miner shall be filed within three years after a medical determination of total disability due to pneumoconiosis which has been communicated to the miner or a person responsible for the care of the miner, or within three years after the date of enactment of the Black Lung Benefits Act of 1977, whichever is later. There is no time limit on the filing of a claim by the survivor of a miner.

(c) There shall be a rebuttable presumption that every claim for benefits is timely filed. However, except as provided in paragraph (b) of this section, the time limits in this section are mandatory and may not be waived or tolled except upon a showing of extraordinary circumstances.

It is presumed that a claim is timely filed unless the party opposing entitlement demonstrates it is untimely and there are no "extraordinary circumstances" under which the limitation period should be tolled. *See* ***Dougherty v. Johns Creek Elkhorn Coal Corp.***, 18 B.L.R. 1-95 (1994).

In the absence of contrary evidence, I find that the present claim for Black Lung Benefits under the Act was timely filed.

MODIFICATION OF LIVING MINER'S CLAIM

Modification may be sought at any time before one year from the date of the last payment of benefits or at any time before one year after the denial of a claim. 20 C.F.R. §725.310(a) (2000) and (2001).

On June 2, 2003, the District Director issued a denial on an initial claim for benefits in a living miner's claim filed in 1993. The Decision became final on July 2, 2003. The miner was granted a modification of the denial on August 25, 2004, and subsequently put into pay status. On September 15, 2004, the Employer appealed the Claimant's award of benefits. The living miner's claim is now before me on appeal.

Because this is an appeal of a modification decision based on a claim filed prior to the amended regulatory provisions, the numerical limitations on medical evidence are not applicable.

An award in a black lung claim may be modified (increased, decreased, or terminated) at the behest of the claimant, employer, or district director upon demonstrating either that (1) a "change in conditions" has occurred, or (2) there was a "mistake in a determination of fact." 20 C.F.R. §725.310 (2000) and (2001). The circuit courts and Benefits Review Board have held that, for purposes of establishing modification, the phrase "change in conditions" refers to a change in the claimant's physical condition. *See* ***General Dynamics Corp. v. Director, OWCP***, 673 F.2d 23 (1st Cir. 1982); ***Director, OWCP v. Drummond Coal Co.***, 831 F.2d 240 (11th Cir. 1987); ***Lukman v. Director, OWCP***, 11 B.L.R. 1-71 (1988) (*Lukman II*).

In determining whether a "change in conditions" is established, the fact-finder must conduct an independent assessment of the newly submitted evidence (all evidence submitted subsequent to the prior denial) and consider it in conjunction with the previously submitted evidence to determine if the weight of the new evidence is sufficient to demonstrate an element or elements of entitlement previously adjudicated against claimant. *See* ***Kingery v. Hunt Branch Coal Co.***, 19 B.L.R. 1-6 (1994) Even if a "change in conditions" is not established, evidence in the entire claim file must be considered to determine whether a "mistake in a determination of

fact" was made. This is required even where no specific mistake of fact has been alleged. *See* ***Consolidation Coal Co. v. Director, OWCP [Worrell]***, 27 F.3d 227 (6th Cir. 1994); ***Jessee v. Director, OWCP***, 5 F.3d 723 (4th Cir. 1993); ***Kingery,*** *supra*; ***Kovac v. BCNR Mining Corp.***, 14 B.L.R. 1-156 (1990).

In the most recent final Order, the District Director issued a denial of a modification request. The miner was seeking to modify Judge Tureck's 1997 Decision denying the claim for benefits. Judge Tureck found the presence of pneumoconiosis, but concluded that the miner had failed to establish that pneumoconiosis arose out of coal mine employment or that the miner was totally disabled. The Director's Decision; therefore, simply maintained the *status quo*. Under the change of conditions analysis, I examine the medical evidence presented since the close of the evidentiary record on July 2, 2003, to determine if the miner has established a change in conditions. In determining whether a "change in conditions" is established, the fact-finder must conduct an independent assessment of the newly submitted evidence (all evidence submitted subsequent to the prior denial) and consider it in conjunction with the previously submitted evidence to determine if the weight of the new evidence is sufficient to demonstrate an element or elements of entitlement previously adjudicated against claimant. *See* ***Kingery v. Hunt Branch Coal Co.***, 19 B.L.R. 1-6 (1994)

INITIAL SURVIVOR'S CLAIM

The survivor's claim was filed by the miner's widow on October 27, 2005. The amended regulations at part 718 and 727 are applicable to this claim.

In order to receive benefits in an initial survivor's claim, the claimant must prove: (1) that the miner had pneumoconiosis, (2) the miner's pneumoconiosis arose out of coal mine employment, and (3) the miner's death was due to pneumoconiosis. 20 C.F.R. § 718.205(a). However, this is a subsequent claim for survivor's benefits. A subsequent claim filed by a surviving spouse, child, parent, brother, or sister shall be denied unless the applicable conditions of entitlement in such claim include at least one condition unrelated to the miner's physical condition at the time of his death. 20 C.F.R. §725.309(d)(3) (2001). The Department proposed the automatic denial of an additional survivor's claim in cases in which the denial of the previous claim was based solely on a finding or findings that were not subject to change.[15]

DISCUSSION

EXISTENCE OF PNEUMOCONIOSIS

Pneumoconiosis is defined as a chronic dust disease arising out of coal mine employment.[16] The regulatory definitions include both clinical (medical) pneumoconiosis, defined as diseases recognized by the medical community as pneumoconiosis, and legal pneumoconiosis, defined as any chronic lung disease. . .arising out of coal mine employment.[17] The regulation further indicates that a lung disease arising out of coal mine employment includes

---

[15] See Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969, 65 Fed. Reg. 79,968 (Dec. 20, 2000).

[16] 20 C.F.R § 718.201(a).

[17] 20 C.F.R. § 718.201(a)(1) and (2) (emphasis added).

any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment." 20 C.F.R. § 718.201(b).

The Fourth Circuit has issued a number of decisions addressing the broad definition of pneumoconiosis in the regulation. "Pneumoconiosis" is a legal term defined by the Act and the judge "must bear in mind when considering medical evidence that physicians generally use "pneumoconiosis" as a *medical or clinical* term that comprises merely a small subset of the afflictions compensable under the Act." Thus, an administrative law judge should also review evidence in light of the much broader legal definition. *See* ***Barber v. Director, OWCP***, 43 F.3d 899 (4th Cir. 1995); *see also* ***Dehue v. Director, OWCP***, 65 F.3d 1189 (4th Cir. 1995); ***Hobbs v. Clinchfield Coal Co.***, 45 F.3d 819 (4th Cir. 1995) ("a medical diagnosis of no pneumoconiosis is not equivalent to a legal finding of no pneumoconiosis").

This case arises within the territorial jurisdiction of the Fourth Circuit. Thus, absent contrary evidence, while evidence relevant to any of the above categories may demonstrate the existence of pneumoconiosis, the adjudicator, in the final analysis, must weigh all of the evidence together in reaching a finding as to whether a miner has established that he has pneumoconiosis. ***Island Creek Coal Co. v. Compton***, 211 F.3d 203, 211, 22 B.L.R. 2-162 (4th Cir. 2000).

X-ray Evidence

Living Miner's Claim

The most recent final Order was issued by the District Director on June 2, 2003, denying the miner's initial claim filed in 1993. The Order became final on July 2, 2003, and was subsequently modified at the request of the Claimant. The Employer appealed the Decision and requested a hearing before this office. Therefore, this case represents an adjudication of the July 2, 2003 denial of the 1993 claim. Because the claim was filed prior to the amended regulations, the numerical limitations on evidence implemented by the new regulations are not applicable.

During the hearings held in Big Stone Gap, Virginia, the Employer submitted numerous x-ray readings. Because the claim is adjudicated under the pre-amended regulations, I do not apply the rules limiting evidence. 20 C.F.R. §725.414. The evidence that I will consider in evaluating the modification request. The assessment will consist of all evidence in the record and developed subsequent to the date of the most recent final Order denying benefits.

Survivor's Claim

In the survivor's claim, I have three readings of two x-rays. The Claimant submits the readings of Drs. Patel and Ahmed. The Employer submits a reading by Dr. Scatarige. The September 23, 2004, x-ray was read by Dr. H. Patel and Dr. Scatarige. The April 9, 2002 x-ray was read by Dr. Ahmed.

Biopsy and Presumption

Dr. Naeye reviewed various slides from a biopsy that was not entered into evidence by the parties. Dr. Naeye did note that in the absence of pulmonary parenchymal tissue, there is no possibility of making or excluding the diagnosis of coal workers' pneumoconiosis. Dr. Naeye did note the presence of a small amount of black pigment present in the tissue. There was no presence of fibrous tissue with admixed collagen, and only a very tiny amount of birefringement crystals of toxic silica.

Dr. Haresh J. Patel and Dr. Joseph Segen submitted cytopathology reports. Dr. Patel examined slides consisting of small amounts of sputum. Examination revealed no malignant cells present and very few carbon containing pigment histiocytes were present. There was no mention of fibrosis. Dr. Segen examined tissue from a right upper lobe biopsy, which revealed fragments with acute and chronic inflammation, negative for malignancy.

Medical Reports

20 C.F.R. § 718.202(a)(4) sets forth:

> A determination of the existence of pneumoconiosis may also be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in Section 718.201. Any such finding shall be based on objective medical evidence such as blood-gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion.

Testimony

A physician who prepared a medical report, admitted under § 725.414, may testify with respect to the claim. 20 C.F.R. § 725.414(c). There are no depositions to consider in this claim.

Other Medical Evidence

There are two treatment notes by Drs. J.G. Patel and H. Patel. There is also a report from the Russell County Health Department Division of TB control. In addition, the record includes a CT-Scan reading by Dr. Scott and testimony by the miner's widow.

RATIONALE

Living Miner's Claim

The existence of pneumoconiosis is based on weighing all types of evidence under 20 C.F.R. § 718.202 together. The presence of pneumoconiosis is based on weighing all types of evidence under 20 C.F.R. § 718.202 together. ***Island Creek Coal Co. v. Compton***, 211 F.3d 203 (4th Cir. 2000).

This case arises within the territorial jurisdiction of the Fourth Circuit. Thus, absent contrary evidence, while evidence relevant to any of the above categories may demonstrate the existence of pneumoconiosis, the adjudicator, in the final analysis, must weigh all of the evidence together in reaching a finding as to whether a miner has established that he has pneumoconiosis. *See* ***Compton.*** *supra*.

The representative for the living miner's claim stated that the evidence for consideration in the modification request would consist of the entire evidentiary record.[18]

The living miner's claim is a 1993 claim, filed prior to the 2001 amended regulations implementing numerical limitations on the designation and consideration of evidence in adjudicating claims. Therefore, I need not apply the rules on limitation of evidence. 20 C.F.R. §725.414

The proponent of a modification request must establish a change in conditions in one of the elements previously adjudicated against the proponent. In determining whether a change in

[18] *See* TR1 at 12. ("TR1") refers to the transcript of the hearing held in Big Stone Gap, Virginia, on April 25, 2007.

conditions is established, I conduct an independent assessment of the newly submitted evidence (all evidence submitted subsequent to the prior denial) and consider it in conjunction with the previously submitted evidence to determine if the weight of the new evidence is sufficient to demonstrate an element or elements of entitlement previously adjudicated against claimant. ***Kingery v. Hunt Branch Coal Co.***, 19 B.L.R. 1-6 (1994) Only medical evidence developed after the prior denial can be considered in demonstrating a change in conditions. Evidence of record prior to July 3, 2002 cannot be considered as new evidence. The Employer has submitted numerous x-ray interpretations of x-rays taken in 2002, and a reading of an x-ray taken in 1993. None of these are considered in my determination of whether a change in conditions has been established because this evidence predates the Order that is sought to be modified.

There are two readings of the September 1, 2003 x-ray by Drs. Scatarige and Scott. Both Doctors conclude there are no pleural or parynchymal abnormalities, but note the presence of sizable masses measuring 5cm, 8cm, and 12 cm. The masses are located in various locations throughout the lungs. Neither Doctor makes a diagnosis of coal workers' pneumoconiosis. Dr. Scatarige's reasoning for not finding pneumoconiosis is based on the lack of small opacities. Dr. Scott indicates that TB is the most likely diagnosis.

There are also three readings of the September 23, 2004 x-ray; these are read by Drs. Scatarige, Scott, and D. Patel. Both Dr. Scatarige and Dr. Scott note the presence of fibrosis. They indicate the lack of change in the size of the masses, but note the possible presence of pleural fibrosis. Dr. Patel indicates that the most likely diagnosis is complicated pneumoconiosis.

There are two readings of the January 7, 2004 x-ray by Drs. Scatarige and Scott. Both Doctors' interpretations are similar to their prior diagnosis on the September 2004 x-ray readings. Dr. Scatarige, however, concludes this time that the changes favor a diagnosis of TB/Sarcoidosis.

There are three readings of the August 10, 2004 x-ray. Unlike prior findings, both Drs. Scatarige and Scott note the increasing size of the masses, now measuring between 8cm to 16 cm. Dr. Scott also notes the presence of fibrosis. The additional reading by Dr. H. Patel suggests the presence of complicated pneumoconiosis with emphysema.

The September 23, 2003 and January 7, 2004, x-rays are not rebutted by the Claimant. In the absence of a rebuttal to the physicians' interpretations of the x-rays, I accept their assessment and diagnosis. Both Doctors note the significant size of the masses evident on the x-rays, but attribute the findings to TB. The August 10, 2004 x-ray is in dispute. Dr. Patel sees a likely diagnosis of complicated pneumoconiosis while Drs. Scott and Scatarige reiterate their prior findings; this time noting the increase in the size of the masses previously found and the occurrence of possible fibrotic reaction in the lungs. The September 23, 2004 x-ray is also in dispute. Drs. Scatarige and Scott again exclude the possibility of pneumoconiosis, and find the size of the masses to have remained constant over the prior two months. Both Doctors, however, see possible fibrotic reaction with the pleura. Only Dr. D. Patel makes a diagnosis of complicated pneumoconiosis. A reading of the March 5, 2004 reading by Dr. H. Patel reveals possible pulmonary infiltrates, but makes no specific diagnosis of coal workers' pneumoconiosis.

I accord greater weight to the readings of Drs. Scott and Scatarige over that of Dr. Harshbhai Patel, who is board-certified but not a B Reader. Both Drs. Scatarige and Scott are dually qualified. Greater weight may be accorded the x-ray interpretation of a dually-qualified (B-reader and board-certified) physician over that of a board-certified radiologist. ***Herald v. Director, OWCP***, BRB No. 94-2354 BLA (Mar. 23, 1995)(unpublished); *see also* ***Zeigler Coal***

Co. v. Director, OWCP *[Hawker]*, 326 F.3d 894 (7th Cir. 2003) Although both Dr. Scatarige and Scott failed to diagnose coal workers' pneumoconiosis, the physicians' findings of significant amounts and size of masses in the miner's lungs must be analyzed and looked at in context with all of the other evidence of record prior to concluding the presence or absence of pneumoconiosis.

Pursuant to ***Compton***, I must consider the cumulative evidence in the relevant categories and weigh all of the evidence together in determining whether the presence of pneumoconiosis has been established.

None of the presumptions of §§718.304, 718.305, or 718.306 are applicable. Therefore, the presence of pneumoconiosis must be established by means of a biopsy report or reasoned medical opinions.

The miner underwent a biopsy and slides from the biopsy were reviewed by Dr. Naeye. Dr. Naeye asserts that because of the absence of parenchymal or pleural tissue, he is unable to make a determination as to the presence or absence of pneumoconiosis. However, he continues to offer an opinion as to the diagnosis of the miner's respiratory condition based on his examination of the slides. He did note the presence of a small amount of black pigment but no evidence of fibrosis. Black pigment and fibrosis is the minimum, according to Dr. Naeye, that must be present for a conclusion that pneumoconiosis is present. In order for a diagnosis to qualify as "pneumoconiosis," there must be evidence that the lung tissue has reacted to the embedded coal deposits. Consequently, black pigment in the lungs, standing alone, does not constitute a finding of pneumoconiosis. On the other hand, observations of black pigment *with associated fibrosis* would qualify as a diagnosis of the disease. Doctor Naeye is correct in his conclusion that pigmentation absent fibrosis is not sufficient for a finding of pneumoconiosis. However, I find Dr. Naeye's overall report inherently inconsistent and not well-reasoned. Dr. Naeye opines that he is unable to make a diagnosis because of the lack of parenchymal or pleural tissue, yet he continued to do exactly what he is advocating one should not or cannot do in this instance. I find Dr. Naeye's conclusions and opinion contradictory and internally inconsistent. Therefore, I give little weight to his conclusions. A report may be given little weight where it is internally inconsistent and inadequately reasoned. *See* ***Mabe v. Bishop Coal Co.***, 9 B.L.R. 1-67 (1986); ***Cranor v. Peabody Coal Co.***, 22 B.L.R. 1-1 (1999) (en banc on recon.)

Biopsy and cytopathology reports submitted in support of the Claimant do little to advance Claimant's position on the issue of pneumoconiosis. Dr. Segen examined lung tissue from the miner's right upper lobe and Dr. Haresh J. Patel completed microscopic examinations of cells derived from the miner's sputum. The examinations revealed acute and chronic inflammation, no malignant cells, and a very tiny amount of black pigmentation; findings that fall short of the evidence required to conclude the presence of pneumoconiosis. No fibrosis is noted.

Dr. J.G. Patel conducted a microscopic examination of upper right lung tissue on February 14, 2003. Dr. Patel did *not* note the presence of black pigmentation or any fibrotic reaction. He concluded that the biopsy fragments revealed acute and chronic inflammation of the upper right lobe. Dr. Patel's examination was confined to the upper right lobe and its probative value on the issue of clinical pneumoconiosis is likewise confined to the area of examination. Nevertheless, in the absence of additional evidence indicating the presence of coal dust deposits and associated fibrosis, the evidence is simply insufficient for a finding of clinical pneumoconiosis.

There are no new medical reports in the living miner's claim subsequent to the date of the prior denial, but there are several CT-Scans and hospital treatment reports. Some of the CT-Scans were performed as part of the miner's laboratory procedures upon admission to and treatment in the hospital. Dr. Hareshbhai Patel interpreted many of these reports as positive for coal workers' pneumoconiosis, commenting that the scans displayed extensive scarring. On one occasion, Dr. H. Patel, on discharge, diagnosed the miner with complicated pneumoconiosis with progressive massive fibrosis and noted that the miner had micropurulent sputum with hemoptysis and black stool, all suggestive of coal workers' pneumconiosis. The diagnosis resulting from the CT-Scans contradict the general observations made on readings of x-rays by the Employer's physicians as well as contrary readings of CT-Scans by Dr. Scatarige. Dr. Scatarige observed that the lack of small round opacities indicative of silicosis/CWP. He indicated the presence of bilateral necrotic masses.

I have reviewed the evidentiary record in the living miner's claim and find that the miner has failed to establish the presence of pneumoconiosis.

The x-ray readings by the Employer's physicians reveal large masses that increased in size over a period of time, but there is insufficient evidence for concluding that these masses demonstrate clinical pneumoconiosis. The numerical superiority of the Employer's x-ray evidence suggests the lack of clinical pneumoconiosis. However, I am not required to defer to the numerical superiority of x-ray evidence, ***Wilt v. Wolverine Mining Co.***, 14 B.L.R. 1-70 (1990), but it is within my discretion to do so, ***Edmiston v. F&R Coal Co.***, 14 B.L.R. 1-65 (1990), although the court disfavors "counting heads". ***Adkins v. Director, OWCP***, 958 F.2d 49, 52 (4th Cir. 1992).

The Employer's own physicians find the presence of sizable masses, increasing significantly over a short period of time. Some readings mention the possibility of fibrosis, but not unequivocally. Although the majority of x-ray evidence is against the Claimant based on the negative findings of CWP by Dr. Scatarige and Dr. Scott, negative x-rays alone should not determine the presence or absence of pneumoconiosis. The Claimant's physicians make a diagnosis of pneumoconiosis and, in certain readings, conclude that complicated pneumoconiosis exists. The Claimant, however, has failed to provide evidence which would substantiate the x-ray readings of the Claimant's physicians in diagnosing clinical pneumoconiosis. Despite the consensus of opinion among physicians that masses on the x-rays measure greater than 1cm and in most readings exceed 6cm, the numerous x-ray readings by the Employer's own physicians indicating masses as large as 16cm are insufficient to conclude that complicated pneumoconiosis exists. These physicians have simply commented on the approximate size of the masses without specifically checking the box indicating A, B, C, or O size nodules. Where a physician finds a large "mass" or "nodule," but does not specifically check a box that it is a size A, B, or C "opacity," then the x-ray interpretation does not support a finding of complicated pneumoconiosis. *See* ***McCoy v. Holly Beth Coal Co.***, BRB No. 05-0818 BLA (May 25, 2006) (unpub.). In the absence of supporting evidence substantiating the positive diagnosis of pneumoconiosis by the Claimant's physicians, I see no basis for exercising my discretion in not deferring to the numerical superiority of the Employer's x-ray evidence. Considering all of the relevant evidence, pursuant to ***Compton***, I conclude that the miner has failed to establish the presence of clinical pneumoconiosis.

However, Clinical pneumoconiosis is only a small subset of the compensable afflictions that fall within the definition of legal pneumoconiosis under the Act. Legal pneumoconiosis has "a broad definition, one that effectively allows for the compensation of miners suffering from a

variety of respiratory problems that may bear a relationship to their employment in the coal mines." ***Rose v. Clinchfield Coal Co.***, 614 F.2d 936, 938 (4th Cir. 1980). "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment. Asthma, asthmatic bronchitis, or emphysema may fall under the regulatory definition of pneumoconiosis if they are related to coal dust exposure. *See* ***Robinson v. Director, OWCP***, 3 B.L.R. 1-798.7 (1981); ***Tokarcik v. Consolidation Coal Co.***, 6 B.L.R. 1-666 (1983). In ***Hughes v. Clinchfield Coal Co.***, 21 B.L.R. 1-134, 1-139 (1999), the Board held that chronic bronchitis and emphysema fall within the definition of pneumoconiosis if they are related to the claimant's coal mine employment. The definition of "legal pneumoconiosis" specifically "includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment." 20 C.F.R. §718.201(a)(2) (2001). For purposes of this definition, a disease "arising out of coal mine employment" includes any chronic pulmonary disease resulting in respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment. 20 C.F.R. §718.201. Furthermore, the issue of causation is subsumed within the definition of legal pneumoconiosis.

The evidentiary record is replete with hospital treatment notes and clinical visits detailing the miner's treatments for various respiratory ailments. In February 2003, Dr. H. Patel makes a diagnosis of COPD with viral tuberculosis and acute exacerbation bronchospasm, Dr. J.G. Patel, in the same month, indicates the miner is suffering from underlying COPD with narrowing of the upper right lobe. Dr. H. Patel, in August 2003, concludes that there is acute bronchitis, COPD, and post cavitary tuberculosis. Again in September, 2003, and October, 2003, Dr. H. Patel indicates the presence of COPD, recurrent bronchitis, post cavitary pulmonary tuberculosis, and acute bronchitis. In December 2003, and January 2004, Dr. H. Patel makes the same diagnosis. It is evident that everyone, including the Employer's physicians, concedes that the miner suffers from one or more respiratory impairments. The issue is whether coal mine dust inhalation caused, contributed to, or aggravated any one of these respiratory impairments. The conclusion of the Employer's physicians is that it did not. The issue of causation, however, is simply absent from most of the Claimant's physicians' reports. Many of the treatment reports submitted by the Claimant's physicians make no attempt to explain on what basis coal dust exposure may have contributed to the miner's respiratory problems.

After reviewing all of the evidence, pursuant to ***Compton***, I find the record insufficient for a finding of clinical pneumoconiosis and conclude that the miner has failed to establish legal pneumoconiosis. Additionally, I have reviewed the entire record in the living miner's claim and conclude that a mistake in fact has not been made. Because eligibility for Black Lung benefits is predicated on the establishment of pneumoconiosis and the miner has failed to establish the presence of pneumoconiosis, I do not need to discuss the element of total disability. This request for modification in the living miner's claim is denied.

Survivor's Claim

There is substantial divergence of opinion regarding the September 23, 2004 x-ray. One physician reads it as negative for pneumoconiosis, no small opacities, and suggesting tuberculosis, while another physician sees large densities possibly complicated pneumoconiosis. Dr. Scatarige's qualifications are superior to that of Dr. H. Patel. A physician's qualifications *at*

the time the interpretation is rendered should be considered. ***Aimone v. Morrison Knudson Co.***, 8 B.L.R. 1-32 (1985). The Claimant has not provided a basis to credit Dr. Patel's diagnosis.

A second film was designated for consideration in the survivor's claim. The April 9, 2002 film was read by Dr. Ahmed as positive and was not rebutted.

Dr. Naeye's review of the biopsy slides yields no evidence of clinical pneumoconiosis. The presence of small quantities of black pigmentation absent associated fibrosis is insufficient to conclude clinical pneumoconiosis is present. The cytopathology and biopsy reports submitted on behalf of the Claimant offer no additional probative value on the issue of pneumoconiosis. Apart from the mention of minute amounts of black pigmentation, there is nothing in the reports to suggest the presence of clinical pneumoconiosis. Both of the examinations performed by Dr. Patel and Dr. Segen fail to provide any evidence which warrants a conclusion that clinical pneumoconiosis is present.

The record also contains a medical report prepared by Dr. Fino asserting that the evidence is insufficient for a diagnosis of complicated pneumoconiosis. According to Dr. Fino, there was resting hypoxemia, but this improved with exercise, indicating that coal mine dust was not a contributor, because the hypoxemia would not improve with exercise. Dr. Fino reviewed an extensive amount of medical evidence dating as far back as 1988. Because of the numerical limitations imposed by the amended regulations in survivor's and living miner's claims, much of this evidence exceeds the scope of permissible evidence that can be designated for consideration and evaluation. The extent to which each piece of evidence contributed to Dr. Fino's conclusions and diagnoses is unclear. I cannot discern the extent to which Dr. Fino's opinion and conclusions are based on the impermissible evidence. Therefore, I accord Dr. Fino's opinion very little probative value.

The remaining evidence consists of various treatment reports by Dr. J.G. Patel, Dr. H. Patel, Dr. Byer, and treatment from the Russell County TB Division Clinic. All reports and treatment indicate the presence of coal workers' pneumoconiosis, emphysema, or tuberculosis. The diagnoses made by some of these physicians of clinical pneumoconiosis is negated by Dr. Naeye's findings, and Dr. Naeye's examination of the tissue slides is not rebutted. Dr. Naeye did find a small amount of black pigmentation; however, black pigment in the lungs, standing alone, does not constitute a finding of pneumoconiosis. A finding on biopsy of black pigmentation shall not be sufficient, by itself, to establish pneumoconiosis. ***Hapney v. Peabody Coal Co.***, 22 B.L.R. 1-106 (2001)(en banc).

At various stages throughout his treatment for respiratory problems, the miner was diagnosed with emphysema, COPD, and tuberculosis. All of these impairments fall under the definition of legal pneumoconiosis if the respiratory ailments are caused by, contributed to, or aggravated by coal mine dust inhalation. ***Barber v. Director, OWCP***, 43 F.3d 899 (4th Cir. 1995); ***Dehue v. Director, OWCP***, 65 F.3d 1189 (4th Cir. 1995); ***Hobbs v. Clinchfield Coal Co.***, 45 F.3d 819 (4th Cir. 1995) However, the nexus between the respiratory impairments and coal mine dust exposure is not fully addressed. An inference cannot be made. The burden is on the Claimant to provide evidence supporting and substantiating the causal connection between the miner's respiratory impairments and coal mine dust exposure.

Reviewing the evidence in all relevant categories and weighing the evidence together, pursuant to ***Compton***, I conclude that the Claimant has failed to establish the presence of clinical or legal pneumoconiosis. Eligibility for survivor's benefits is predicated on the establishment of pneumoconiosis. Because the Claimant has failed to establish the presence of pneumoconiosis, I

need not consider whether the miner's death was due to pneumoconiosis. The survivor's claim is denied.

CONCLUSION

In summary, the Claimant has not established the presence of pneumoconiosis in the living miner's claim or the survivor's claim. I find that the Claimant has failed to establish a required element of proof. ***Oggero v. Director, OWCP,*** *supra.* As a result, because both claims are initial claims, there is no need to evaluate the remainder of the issues. A review of the evidentiary record reveals no mistake of fact in the living miner's claim.

ORDER

It is hereby **ORDERED** that the living miner's claim of **W.K.** is **DENIED**.

It is hereby **ORDERED** that the survivor's claim of **B.K.** is **DENIED**.

A

DANIEL F. SOLOMON
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.478 and 725.479. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board. After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed. At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481. If an appeal is not timely filed with the Board, the decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).